
Name:	Grievance, Appeal, Administrative Hearing Policy
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I. POLICY

Capitol Dental Care (CDC) is committed to member satisfaction. In order that members have a positive care experience and to ensure that their rights are protected, CDC has implemented multiple systems to ensure that grievances and appeals are handled in a confidential, unbiased, professional, timely manner and that practices are consistent with all applicable OHP and federal rules and regulations.

CDC members, members' representatives, and/or a provider acting on behalf of the member have the right to engage in the grievance system to resolve concerns that they may have with CDC, its providers, or any of its subcontracted or otherwise downstream or associated entities.

CDC's Appeals and Grievances Manager is primarily responsible for management of the grievance system (outlined below) as well as appeals and administrative hearings. The Member Services team assists in this effort by making sure that the Appeals and Grievances Manager receives the proper information and that members are appropriately placed in contact with her.

Efforts made to resolve a grievance often include communicating with the grieving party and coordinating with appropriate departments to obtain member information consistent with CDC confidentiality policies and other federal rules and regulations, such as HIPAA and HITECH. CDC maintains the same confidentiality and security standards in reporting the grievance data to OHA, CCOs, and other entitled entities.

II. GRIEVANCE PROCEDURES

Grievance Definition

Any expression of dissatisfaction, expressed verbally or in writing.

Receipt of Grievances through Provider

Grievances that are expressed in the dental office may be reported by the office staff or provider, at times, on behalf of the member. In other instances, the member is given information by the office to call CDC and work with its staff to reach a resolution.

All PCD / Dental Office are in possession of CDC's contact information and have been informed to share this information with a member, whenever a member would like to discuss a grievance.

Providers may file a grievance on behalf of the member with the member's written consent.

Receipt of Grievances through Member Services

CDC may become aware of members' grievances in a variety of ways and through a variety of people. No matter the source or the form of the information, CDC will work to resolve all members' grievances and will ensure that they are accurately captured and tracked.

CDC staff will provide assistance to members with a grievance, including letting them know that their concern has been recorded as a grievance.

Grievances are often expressed verbally. CDC employees and providers are encouraged to resolve grievances within their authority level, as quickly and fully as possible. Verbal grievances may be resolved with a verbal response, but a written response is also made.

A grievance can be made in whatever language or form of communication that is used by the member (or the member's representative), and CDC will communicate in like manner. If the member has advised CDC that they will be using a representative, CDC will work with the representative to resolve the grievance.

All grievances are logged in the Clinical Integration Manager (CIM) system in the member's file. Grievances reported through another process, such as direct contact with the OHP Client Services Unit will also be logged.

Verbal grievances are logged in CIM. The CIM record states who filed the grievance; the member's identification number, address, and phone number; details of the grievance; the name of the related provider or clinic if applicable; what the member's desired resolution is; and the date the grievance was made.

This is often performed by the CDC Appeals and Grievances Manager; however, all members of the Member Services team are able to identify and capture the details of a grievance.

Any issues that are not resolved over the phone while speaking with the member, i.e., "one-phone-call resolutions," are handled by the Appeals and Grievances Manager, the Call Center Supervisor, or the Director of Member Services. Further investigation may require contacting the member and/or the provider as well as requesting and reviewing clinical or billing records. For grievances involving a provider or clinic, CDC may notify them of the concern so that they have an opportunity to participate in an unbiased manner in the resolution of the grievance.

It is also necessary, at times, for CDC staff, including the Appeals and Grievances Manager, the Director of Member Services, the Dental Director, or the Compliance Officer to discuss a particular grievance with the provider or office in order to coach and correct so that similar grievances are preempted.

Written grievances are largely processed in the same manner as verbal grievances. The documentation is delivered directly to the Appeals and Grievances manager, though. From that point, the same procedure is followed as outlined above.

If a grievance is received in writing, an answer must be delivered in writing. CDC may also

provide a verbal resolution to the member in addition to the written response.

Resolving Grievances

An initial response is made within 5 days of receipt of a grievance that serves one of two purposes:

- (1) The response can inform the member that their grievance has been resolved, indicating and explaining the outcomes.
 - CDC refers to these as “resolution” letters.
 - No further communications are required about this grievance.
- (2) The response can inform the member that additional time (up to 30 days from the date of receiving the grievance) will be required to resolve their grievance, including the reason why the delay is necessary.
 - CDC refers to these as “acknowledgment” letters.
 - Another letter is sent within 30 days of the receipt of the grievance, which explains the resolution of the grievance and the outcomes.
 - CDC also refers to these as “resolution” letters.

Responses to grievances address each aspect of the grievance and the associated outcomes; they also explain the reason for CDC’s decision or actions. Responses also inform members of any applicable due process rights.

The reasons why additional time may be required to resolve the grievance can vary but often include the time to secure pertinent information in the possession of a third party, e.g., chart notes or x-rays, and the time to discuss the facts with the provider or office. Another reason can be that the Dental Director may need to review the particular issue and cannot perform the review in the typical timeframe.

Regardless of whether the grievance can be resolved within 5 days or requires additional time—CDC resolves each grievance as expeditiously as the member’s health requires (at minimum, within the stated timeframes).

Grievance Documentation

In addition to the information stored in the CIM system (as detailed above), information relating to all member grievances is maintained in the Grievance Log, which includes but is not limited to the following:

- Member CCO
- Member name
- Member ID number
- Date of receipt of grievance
- Grievance type
- Date of resolution
- Number of days to resolution
- Provider name
- Clinic name

- Description of grievance
- Description of resolution
- Whether an extension was required
- Whether the grievance dealt with an issue of health equity
 - Such issues are reported to the CCOs, which then report to OHA.

Grievance files are maintained for all grievance issues, which contain all pertinent information, including notes, communications with the member, communications with the provider, etc. These records will be retained indefinitely or for a minimum of ten years.

CDC staff who participate in the identification, capturing, documenting, and resolving of grievances will:

- Not have been involved in any previous level of review or decision making and
- Have the necessary clinical expertise to treat the member's condition if the grievance is based on clinical issues or determinations.
 - CDC shall note the credentials of the reviewer early in the review in order to determine that the appropriate level of clinical provider was involved in making the decision.

Grievance Elevation to OHP Client Services Unit (CSU)

If a member is dissatisfied with the resolution of their grievance, the member may elevate their grievance to OHP Client Services Unit (CSU) (800-273-0557) or to the OHA's Ombudsman office (503-947-2346 or 877-642-0450). This information will be included in all grievance resolution letters.

CDC will fully cooperate with any investigation involving one or both of these organizations (including supplying all requested records and information) and will consider implementing any recommended actions in response to that investigation.

Grievance Monitoring

The CDC Quality Improvement Committee (QIC) meetings include review of all grievances that have been received since the previous meeting. A copy of the Grievance Log is supplied to the Committee, including the appropriate level of detail (excluding PHI or other confidential information), for review.

Any and all grievances that relate to quality of care are discussed one by one by the Committee. A determination will be made for each quality of care grievance as to whether any additional actions are required beyond that which CDC has already taken in relation to the issue.

Grievance data is analyzed for trends or other concerns. Recommendations, projects, trainings, studies, corrective action plans, etc. may result from these analyses in order to improve the quality of CDC's services delivery system.

At times, the QIC may request an update at a future meeting for a grievance that has been reviewed. If this is the case, the Appeals and Grievances Manager will prepare such for the

Committee's information.

Grievance Reporting

Grievance data is reported to the CCOs on a quarterly basis, as required by Exhibit I of the CCO contract. CDC uses the State template for this reporting and submits it timely for each CCO. Any accompanying samples are also sent with the grievance data.

Any additional reporting requirements that come from CDC's contracts with the CCOs or other sources will be completed and delivered timely and accurately.

Member and Provider Education Regarding Grievances

CDC's Member Handbook will inform members of the grievance system procedures. This includes making them aware of their right to file a grievance, instructions on how to proceed, contact information for the appropriate parties, etc. This information is also found on CDC's website, outside of the Member Handbook, but a link to the Member Handbook is available through the website as well.

CDC's Provider Manual (given to providers at time of contracting) contains similar information as the Member Handbook and informs providers of members' rights to file a grievance about any expression of dissatisfaction that the member may have relating to CDC's delivery of services/administration of benefits. CDC providers are also informed that they may not discourage a member from filing a grievance or encourage a member from withdrawing a grievance that has been filed. This is also true of filing an appeal or a hearing request. Relatedly, providers may not retaliate against a member (including requesting their disenrollment) for using the grievance and appeal system.

CDC staff will also inform members of their right to file a grievance and help them in doing so if the member expresses dissatisfaction or concern with their experience.

III. THE APPEAL PROCESS INVOLVING NOTICES OF ADVERSE BENEFIT DETERMINATION

Notice of Adverse Benefit Determination

A Notice of Adverse Benefit Determination (NOABD) is a document that is given to a member when a benefit determination is made that negatively impacts the member. A determination can be defined as an action or the absence of an action, so long as the effect thereof is adverse to the member.

Adverse benefit determinations may include but are not limited to the following:

- the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
- the reduction, suspension, or termination of a previously authorized service;
- the denial, in whole or in part, of payment for a service;
- the failure to provide services in a timely manner, as defined by the State;
- the failure to act within the timeframes provided in § 438.408(b)(1) and (2) regarding

- the standard resolution of grievances and appeals;
- for a resident of a rural area, the denial of an enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network;
- and/or the denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

NOABDs will contain at a minimum the following elements:

- the date the letter was mailed;
- CDC's name, address, and phone number;
- the name of the member's provider and the name of the requested service provider;
- the member's name, address, and ID number;
- the date of the service request;
- the effective date of action;
- toll-free number for TTY/TTD for hearing impaired
- information regarding the ability to access interpreter services free of charge to the member
- a description of the action that CDC has taken or intends to take, including whether denying, terminating, suspending, or reducing service or denying payment in whole or in part;
 - a clear description of the reason for the action, which could include the following examples:
 - Treatment is not covered.
 - The item requires pre-authorization and was not pre-authorized.
 - The individual was not a CDC member at the time of the service or is not a CDC member at the time of a requested service.
 - whether CDC considered any other conditions of the member if the requested service was below the OHA funded line of covered services, such as co-morbidity factors;
- references to specific statutes and/or OARs relating to each reason identified for the action; and
- the right to request any records or other materials that were used in making the determination.

NOABDs will advise the member at a minimum of the following:

- The member's right to be provided reasonable access to/copies of all documents/records/other information relevant to the adverse determination. These are available free of charge.
- The member's right to file an appeal within 60 days of the adverse determination, including information on exhausting the appeal process. This includes the right to request a hearing within 120 days of receiving a Notice of Appeal Resolution (NOAR) or when CDC fails to meet appeal timeframes.
 - Circumstances under which an appeal may be expedited and how to request expedited status. The member, their representative, or their provider may request expedited status of an appeal.

- The procedures for exercising the abovementioned rights
- The member's right to continued benefits pending the resolution of the appeal, including how to request the continuation and the circumstances under which the member might be required to pay for the services.
- CDC's contact information, including telephone number and physical address and the ability to communicate with CDC for additional information.

Timeframes

NOABDs are sent to members according to prescribed timeframes (by federal or state law as well as contractual obligations):

- If relating to the termination, reduction, or suspension of a previously authorized service, the NOABD will be sent within 10 calendar days of the determination's effective date.
 - Exceptions include:
 - The member provides a signed, clearly written statement that they no longer desire services or the member provides information that requires termination or reduction of services and they indicate that they understand that this must be the result of supplying the information.
 - The member has been admitted to an institution where they are ineligible for covered services from the provider.
 - The member's whereabouts are unknown, the post office returns mail without a forwarding address, and OHA has no other address for the member.
 - CDC establishes the fact that another State, territory, or commonwealth has accepted the member for Medicaid services.
 - A change in the level of care is prescribed by the member's provider.
 - The effective date of the determination will occur in fewer than 10 calendar days (in accordance with 42 CFR 483.12(a)(5)(ii)), related to discharges or transfers and long-term care facilities.
 - The member has passed away.
 - CDC may also shorten the period of advance notice to 5 calendar days before the effective date of the determination if CDC has facts indicating that an action should be taken because of probable fraud by the CDC member. Whenever possible, these facts should be verified through secondary sources.
- If relating to the denial of payment, the NOABD will be sent **at the time the determination is made** that affects the member's claim.
- For standard prior authorizations that deny a requested service or that authorize a service in an amount, duration, or scope that is less than requested—the NOABD will be sent as expeditiously as the member's health condition requires and **within 14 calendar days** following receipt of the request for the service, except that:
 - Some requests may require more time to produce a determination. If that is the case (or if the member requests an extension), the NOABD may be sent within an additional 14 calendar days of the receipt of the request.

- CDC must justify to OHA/the CCOs that this is necessary and in the member's best interest.
- For expedited service requests, a decision must be made and notice provided thereof as quickly as the member's health conditions allow, but **not later than 72 hours after** receipt of the expedited request.
 - If additional information is required to gather additional information (or if the member requests an extension), the NOABD may be sent within 14 days of the expedited request.
 - CDC must justify to OHA/the CCOs that this is necessary and in the member's best interest.
 - In such an instance, the member will receive written notice of the extension and will be informed of the right to file a grievance if they disagree with that decision.
 - CDC must issue and carry out its prior authorization determination as expeditiously as the member's health condition requires, and no later than the date the extension expires.
- For untimely prior authorization decisions, **on the date that the timeframes expire**.
 - Untimely decisions are those not reached within the timeframes specified above.
 - Such failures constitute a denial of member rights and is therefore an adverse action by definition, and an NOABD will be sent to the member, accordingly.

IV. APPEAL PROCEDURES

Appeal Requests

Members may make an appeal request of an adverse determination made by CDC either verbally or in writing. Verbal requests are treated as formal appeals and must be confirmed afterwards in a signed writing. Expedited appeal requests may be made in the same fashion; however, expedited appeal requests do not need to be confirmed in writing.

Providers acting on behalf of the member and with the member's written consent may file appeal requests in the same manner mentioned above. It is important to note that CDC will not take any form of punitive action against a provider who supports a member's appeal or who requests an expedited resolution.

Other parties to the appeal, including a member representative, the Plan, or the legal representative of a deceased member's estate shall have standing on behalf of the member, for both appeals and contested case hearings.

CDC will review and consider all documentation submitted by the member or on the member's behalf by one of the parties mentioned above when making benefit determinations, regardless of whether such information was considered when making the initial determination.

Request Process

Appeal requests must be received no later than 60 calendar days from the date on the NOABD.

Members are instructed in the NOABD to contact CDC to begin the appeal process.

The Appeals and Grievances Manager will mainly be responsible for the appeal resolution. Other individuals who may be involved with the appeals process include the Director of Member Services, the Dental Director, other Member Services representatives, etc.

When the member is assigned to a CCO, CDC will coordinate with the CCO to process the appeal—as the CCO is the final adjudicator of appeals in those instances. CDC will often present its suggested determination and supporting documents to the CCO so that it may make its own independent determination.

CDC staff who act on appeals will comply with the following:

- Will not have been involved in any previous level of review or decision making and will not be subordinate to any reviewer involved in the initial review of the request;
- Will have clinical expertise necessary to treat the member's condition if the appeal is based on medical appropriateness or clinical issues.
 - CDC shall note that the credentials of the reviewer early in the review in order to determine that the appropriate level of clinical provider was involved in making the decision. In addition, this reviewer shall review all denials from an expedited resolution of an appeal or a grievance.

Appeal requests are forwarded to the Appeal and Grievances Manager with a received date, which is documented in the CIM system under the member's file as well as in the Appeals Log. The Appeals and Grievances Manager then coordinates and facilitates the appeal to an informed determination within the appropriate statutory timeframes—which includes the following:

- CDC shall process each appeal as expeditiously as the member's health condition requires and within **no later than sixteen (16) days** from the day CDC receives the appeal.
 - Where requested, a member may be granted an extension of up to 14 additional days; or if CDC shows that there is a need for additional information.
 - As part of this request, CDC must justify to OHA/the CCO that the delay is necessary and in the member's best interest. This applies to both standard and expedited appeal requests.
- If CDC extends the timeframes, it shall, for any extension not requested by the member, give the member a written notice of the reason for the delay **within two (2) calendar days**. This notice must be sent, whether the appeal request is standard or expedited.
 - A member may file a grievance for CDC's decision to extend the timeframe.
- CDC will resolve each expedited appeal request and provide notice as expeditiously as the member's health condition requires, **within seventy-two (72) hours** from the time that the approved expedited request was made.
 - CDC shall make an expedited decision for cases in which a provider indicates

or CDC determines that following the standard appeal timeframe could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function.

- CDC staff will provide assistance with inquires related to NOABDs and the appeals/hearing process, including how to begin those processes. This also includes providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capacity.
- CDC shall ensure that the member is given reasonable opportunity to present evidence of allegations in person as well as in writing. CDC shall inform the member of the limited time available for this in the case of expedited requests.
- CDC shall ensure that the member is given an opportunity before and during the appeals process to examine any dental/medical records or other pertinent documents considered during the appeal process. The member is notified of his or her right to submit documents or other information pertinent to the appeal.
- The Notice of Appeal Resolution shall be in writing. For denied requests for expedited resolution of an appeal, CDC shall make a reasonable effort to provide prompt oral notice within 2 days in addition to the written resolution.
- CDC will handle appeals in a confidential manner, including the storage and communication of member information.

Notice of Appeal Resolution

Once a decision is reached, a written notice is sent to the CDC member called a Notice of Appeal Resolution (NOAR), including the following:

- Date of appeal request
- Date of NOAR
- Date of NOABD sent previously
- CDC member's name and identification number
- Description of the adverse determination being appealed
- The appeal decision and an explanation thereof
- Whether continuing benefits was requested and provided
- References to applicable rules governing the appeal decision
- Toll free number for TTY/TTD for hearing impaired
- The contact and telephone number for additional information
- Information regarding accessing interpreter services
- Notice of CDC member's rights to an administrative hearing
- Copy of the OHA forms "Notice of Hearing Rights" and "Appeal and Hearing Request"

In the case where a member is assigned to a CCO, the CCO will send the NOAR to the member.

Confidentiality

CDC shall keep all healthcare information concerning a member's request confidential, consistent with appropriate use or disclosure as defined in 45 CFR 164.501, and include providing member assurance of confidentiality in all written, oral, and posted material in grievance and appeal processes.

Documents Available

Grievance and appeal forms are made available and accessible to members (OAR 410-141-3875). In all CDC offices (including dental and administrative), the following forms will be made available to members upon request:

- 1) OHP Complaint Form (OHP 3001);
- 2) MCE appeal forms;
- 3) Hearing request form (MSC 443) and Notice of Hearing Rights (OHP 3030); or
- 4) The Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) or approved facsimile.

Expedited Appeal Requests

If CDC determines (upon request from the member or the Provider) that taking the time for a standard resolution could seriously jeopardize the CDC member's life, health, or ability to attain, maintain or regain maximum function, it will approve the request for an expedited appeal.

When CDC determines to uphold its initial adverse determination at the resolution of an expedited appeal, CDC informs the member of the right to request an expedited hearing in the NOAR letter. Included with the letter are copies of the appropriate OHA documentation/forms to begin that process.

CDC makes every effort to accommodate the member's request for an expedited appeal; however, there are circumstances where a determination is made that an expedited appeal is not in the best interest of the member. This may occur where the need for additional, difficult-to-obtain documentation is required. In such a case, the appeal is processed in accordance with the standard timeframe outlined above.

CDC shall make reasonable efforts to give the member prompt verbal notice of the denial for an expedited appeal resolution. CDC will send a written notice within seventy-two (72) hours of receipt of the appeal request. This notice will include the right of a member to request an expedited hearing who believes that a standard hearing could seriously jeopardize their life or health or their ability to attain, maintain, or regain maximum function.

CDC will not take any punitive action against a member that has requested an expedited resolution in the appeal process (or a provider who has made the request on behalf of a member).

Continuation of Benefits Pending Appeal or Administrative Hearing

CDC must continue the member's benefits during the appeal and hearing process if:

- The CDC member, their representative, or the provider files a timely request for an appeal or a hearing;
- The request involves the termination (including the expiration of a previously approved course of treatment or provision of services), suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider;
- The original period covered by the original authorization has not expired; and
- The CDC member requests extension of the benefits.

If the member's benefits are continued as outlined above, the benefits must be continued until one of the following occurs:

1. The member withdraws the appeal or hearing request;
2. Ten days pass after CDC mails the NAOR, unless the member has requested an administrative hearing with continuation of benefits within the 10-day timeframe;
3. A final order is issued at hearing that is adverse to the member; or
4. The time period or service limits of a previously authorized service have been met.

If the final resolution of the appeal or administrative hearing is adverse to the CDC member, i.e., upholds CDC's action—CDC may recover the cost of the services furnished to the member while the appeal or hearing was pending, to the extent that they were furnished solely because of the requirements of this section and the applicable statutes and rules.

If the hearing decision reverses CDC's decision to deny, limit, or delay services that were not furnished while the appeal was pending, CDC must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires. If the member did receive the services while the appeal was pending, CDC must pay for the services.

CDC's communications with providers regarding preauthorizations, denials, and their related statuses help providers understand the process for continuation of benefits as outlined above. All providers are copied on NOABDs, NOARs, and hearing outcomes.

If continuation of benefits occurs, CDC alerts claims processing to reverse preauthorization denials and to pay related claims when presented.

Appeals Monitoring

CDC reports appeals data to the CCOs on a quarterly basis as part of the Exhibit I deliverable. This information is analyzed for trends or troubling outcomes. The Quality Improvement Committee reviews this information from time to time as well.

V. ADMINISTRATIVE HEARING

Request for Expedited Administrative Hearing

Members have the right to request an administrative hearing after completing the appeals process as outlined above, within 120 calendar days from the date of the NOAR. CDC provides OHA/the CCOs copies of all pertinent materials up to that point, including the NOABD and NOAR within 2 business days of standard requests. OHA notifies involved

parties of the hearing date.

If the member believes that taking the time for a standard resolution of a request for an administrative hearing could seriously jeopardize their life or health or ability to attain, maintain or regain maximum function may request an expedited hearing. CDC will submit relevant documentation to OHA within, as nearly as possible, 2 working days for a decision as to the necessity of an expedited Administrative Hearing. OHA shall decide within, as nearly as possible, 2 working days from the date of receiving the documentation applicable to the request, whether the member is entitled to an expedited hearing.

If OHA denies the request for an expedited hearing, it must:

- Handle the request for Administrative Hearing in accordance with OAR 410-141-0264; and
- Make reasonable efforts to give the member prompt verbal notice of the denial and follow up within 2 calendar days with a written notice.

If an administrative law judge (ALJ) reverses a decision made by CDC to deny, limit, or delay services that were not furnished while an appeal was pending—CDC will authorize or provide the disputed services to the member as promptly and as expeditiously as the member's health condition requires but **no later than seventy-two (72) hours** of the ALJ's decision.

In the case that CDC fails to adhere to notice and timing requirements, the member is deemed to have exhausted the appeals process, and the member may initiate a contested case hearing.

Monitoring Administrative Hearing Process

CDC maintains a Hearing Log, incorporating similar information to the Appeals Log.

CDC reports hearings data to the CCOs on a quarterly basis as part of the Exhibit I deliverable. This information is analyzed for trends or troubling outcomes. The Quality Improvement Committee reviews this information from time to time as well.

V. Additional Information

In all investigations or requests from the Department of Human Services Governor's Advocacy Office, the Authority's Ombudsperson or hearing representatives, the MCE, and participating providers shall cooperate in ensuring access to all activities related to member appeals, hearing requests, and grievances including providing all requested written materials in required timeframes.

CDC shall provide information to members regarding the following:

- 1) An explanation of how MCEs shall accept, process, and respond to grievances, appeals, and contested case hearing requests;
- 2) Member rights and responsibilities; and
- 3) How to file for a hearing through the state's eligibility hearings unit related to the member's current eligibility with OHP.

CDC's Grievance, Appeal, and Hearing Policy are specifically designed to be culturally and linguistically responsive. The policy complies with state and federal laws. See 410-141-3735(6); 410-141-3875 through 410-141-3915.

In compliance with Title VI of the Civil Rights Act and ORS Chapter 659A, CDC shall review and report to the Oregon Health Authority, as outlined in the CDC-OHA contract, complaints that raise issues related to racial or ethnic background, gender identity, sexual orientation, socioeconomic status, culturally or linguistically appropriate service requests, disability status, and other identity factors for consideration in improving services for health equity. CDC provides written notice to Members of CDC's nondiscrimination policy and process to report a complaint of discrimination on the basis of race, color, national origin, religion, sex, sexual orientation, marital status, age, or disability in accordance with all Applicable Laws including Title VI of the Civil Rights Act and ORS Chapter 659A.

CDC's notice of grievance resolution shall comply with OHA's formatting and readability standards in OAR 410-141-3585 and 42 CFR §438.10. CDC shall write the notice in language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing the grievance resolution.

CDC shall promptly cooperate with any investigations and resolution of Grievance by either or both OHP Client Services Unit or OHA's Ombudsman as expeditiously as the affected Member's health condition requires, and within required timeframes.

CDC shall make its written materials that are critical to obtaining services, including, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices available in the prevalent non-English languages in its particular service area.

Parties to a Contested Case Hearing include:

- (1) The Member and their Representative;
- (2) CDC; and
- (3) The legal representative of a deceased Member's estate.

Expedited hearings are requested using Authority form MSC 443 or other Division approved appeal or hearing request forms. OHA prefers that CDC issue the 3302 form with the NOAR.

CDC may, consistent with the state's usual policy on recoveries and as specified in the CDC-OHA contract, recover the cost of continued services furnished to the member while the appeal or state fair hearing was pending if the final resolution of the appeal or state fair hearing upholds CDC's adverse benefit determination.

CDC only has one level of appeal for members, and members shall complete the appeals process prior to requesting a contested case hearing.

Upon receipt of an appeal, CDC shall:

- 1) Obtain documentation of all relevant facts concerning the issues, including taking into

account all comments, documents, records, and other information submitted by the member or their representative.

- 2) Ensure staff and any consulting experts making decisions on the appeal are:
 - a. Not involved in any previous level of review or decision making nor a subordinate of any such individual.
- 3) Ensure staff and any consulting experts making decisions on the appeal are:
 - a. Not receiving incentivized compensation for utilization management activities by ensuring that individuals or entities who conduct utilization management activities are not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

If the member files a request for an appeal or hearing with OHA prior to the member filing with CDC, OHA shall transfer the request to CDC and provide notice of the transfer to the member. CDC shall:

- 1) Review the request immediately as an appeal of CDC's notice of adverse benefit determination;
- 2) Approve or deny the appeal within 16 days and provide the member with a notice of appeal resolution.

Upon receipt of an appeal, CDC shall, within five business days, resolve or acknowledge receipt of the appeal to the member and the member's provider where indicated.

In sending NOABDs and NOARs, CDC must use an Oregon Health Authority (OHA) approved form unless the member is a dually eligible member of affiliated Medicare and Medicaid plans, in which case the CMS Integrated Denial Notice may be used as long as it incorporates required information fields in Oregon's NOABD.

CDC uses easily understood language and format. OHA defines "easily understood" as 6th grade reading level or lower using the Flesch-Kincaid readability scale. CDC uses a minimum 12-point font or large print (18 point).

In the NOABD, CDC includes a language access tagline in 18-point font which explains:

- 1) The availability of written translation or oral interpretation to understand the information provided, how to request auxiliary aids and services for members who have limited English proficiency or a disability, as well as alternate formats at no cost, and
- 2) The toll-free and TTY/TDY telephone number of the MCE's member/customer service unit.

Taglines must also be located at the beginning of the member handbook for the ease of the member.

In the NOABD, CDC includes a language access statement with the 24 translated languages in at least 12-point font. CDC also includes its Nondiscrimination Statement.

CDC must cause its participating providers and subcontractors to comply with the Grievance and Appeal System requirements set forth in Exhibit I.

CDC gives members timely and adequate NOABD in writing consistent with requirements in OAR 410-141-3885 and in 438.10.

When CDC makes an adverse benefit determination, CDC must notify the requesting provider and give the member and the member's representative a written NOABD.

CDC must provide copies of the following forms to members when it issues an NOABD:

- 1) The Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) or approved facsimile (OHA preferred form); or
- 2) Hearing request form (MSC 443) and Notice of Hearing Rights (OHP 3030).

CDC must retain and keep accessible all notices of adverse determination and any documentation, logs and other records for adverse benefit determinations whether in paper, electronic, or other form for a minimum of 10 years. CDC must communicate these policies and procedures to subcontractors.

VI. Revision Activity

Modification Date	Change or Revision and Rationale	Effective Date of Policy Change
04/15/2005	Annual Update	04/15/2006
10/01/2006	Annual Update	10/01/2006
12/09/2008	Annual Update	12/09/2008
12/01/2010	Annual Update	12/01/2010
01/01/2012	Annual Update	01/03/2012
10/11/2014	Guidance update from community partner	10/15/2014
12/03/2014	Annual Review/Update	12/03/2014
06/22/2016	Guidance/audit update from community partner	6/22/2016
1/4/2018	Updated to reflect that the CCO is the final adjudicator of all appeals.	1/4/2018
1/18/2018	Updated to reflect new timeframes	1/18/2018
1/4/2019	Annual Review, update to formatting and editing of content	1/3/2020
1/28/2020	Several revisions/additions in response to HSAG audit findings	2/5/2020
2/28/2020	Update information	2/28/2020
3/1/2021	Update information	3/1/2021

VII. Affected Departments:

All CDC Administrative Staff
All CDC Providers

VIII. References:

CDC Member Service Guide

CDC Provider Services Guide
CDC Notice of Adverse Benefit Determination
CDC Notice of Appeal Resolution
OAR 410-141-0260 through 410-141-0266
CDC Pre-Authorization Policy and Procedures
CDC Confidentiality Policy and Procedures